Department of Health and Human Services

Office of Inspector General

Semiannual Report to Congress

October 1, 2024–March 31, 2025

Contents

A Message From the Acting Inspector General

I am pleased to submit this *Semiannual Report to Congress* summarizing the activities of the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) for the 6-month period ending on March 31, 2025.

OIG follows the data and adheres to clearly defined accountability standards to provide HHS and Congress with a well-informed perspective, independent oversight, and actionable recommendations. OIG's multidisciplinary workforce of dedicated experts includes law enforcement agents, auditors, evaluators, attorneys, program specialists and analysts, and digital and technology specialists. OIG's work is uniquely focused on combating fraud, waste, and abuse in HHS programs to ensure that those served by the programs receive the intended benefits from the American taxpayers' investments.

As described in this semiannual report, OIG's total monetary impact during the reporting period was $16.61 billion, including $3.51 billion in investigative receivables, $451 million in audit receivables, and $12.65 billion in potential cost savings. OIG consistently delivers a strong return on investment (ROI) through its oversight and enforcement. OIG's ROI is $11:$1 (a 3-year rolling average of expected recoveries and receivables from OIG work). Our enforcement efforts resulted in 744 civil and criminal actions during this reporting period, including settlements resulting from the use of OIG's Civil Monetary Penalties Law authority and criminal convictions. Additionally, we identified and excluded 1,503 bad actors from participation in federally funded health care programs, ensuring that untrustworthy actors will not receive Federal health care program payments.

OIG is the leading Federal agency focused on combating health care fraud, holding wrongdoers accountable through criminal and civil investigations and administrative enforcement actions. As fraudsters grow increasingly sophisticated with complex schemes that use technology to amplify and swiftly replicate their reach, OIG's law enforcement agents use cutting-edge data and investigative techniques to pursue and stop them. The magnitude of harm identified by OIG is consequential. For example, during this reporting period an OIG investigation resulted in an operator of a home health agency being sentenced to 12 years in prison and ordered to pay more than $99 million in restitution for her part in a fraud scheme involving billing for services never provided, kickbacks, and other unlawful conduct.

OIG audits, evaluations, and investigations consistently identify a high risk of fraud, waste, and abuse in the Medicare Advantage risk adjustment program, which provides higher payments to Medicare Advantage plans for sicker enrollees. For example, three audits issued during the reporting period found $13.6 million in net overpayments to three Medicare Advantage plans resulting from incorrect diagnosis coding used to calculate risk adjustment payments. An OIG evaluation found that diagnoses reported only on health risk assessments (HRAs) and HRA-linked chart reviews generated $7.5 billion in Medicare Advantage risk-adjusted payments for

2023, and $4.2 billion of these payments came from in-home HRAs. Inaccurate diagnoses from these in-home HRAs and associated chart reviews may have resulted in improper payments. Finally, a Medicare Advantage plan OIG investigated will pay up to $98 million to resolve alleged violations of the False Claims Act from submitting or causing the submission of invalid diagnosis codes to Medicare to increase the risk-adjusted payments it received. OIG will be monitoring the Medicare Advantage plan pursuant to a corporate integrity agreement. With a combination of enforcement, audits, and evaluations, OIG finds improper and fraudulent payments, holds wrongdoers accountable, and identifies ways the Medicare Advantage program can be improved to prevent fraud and improper payments in the future.

OIG also has found lapses in administration and monitoring of HHS grants and contracts that have raised costs and resulted in waste. During the reporting period, OIG audited a contract that ballooned from an initial award of slightly more than $300,000 to more than $19 million for a 9-month period of performance. Central to the audit's findings was a lack of compliance with Federal contract competition and monitoring requirements.

As evidenced by this report, OIG's enforcement and oversight not only safeguard taxpayer dollars but also improve the quality and efficiency of HHS programs. While the statistics of our work are an impressive part of the story, it is our impact on the lives of nearly every American family that completes the story. No dollar value can be assigned to these results—harms to patients prevented by keeping bad actors out of Federal programs; quality services enhanced by maintaining a vigilant and exacting oversight eye; and program integrity improved to shield Federal programs from the next fraudulent, malicious attack. With sustained support, OIG is poised to continue to deliver extraordinary outcomes for the American people.

We appreciate the continued support of Congress and HHS for OIG's important work.

/s/

Juliet T. Hodgkins

Acting Inspector General

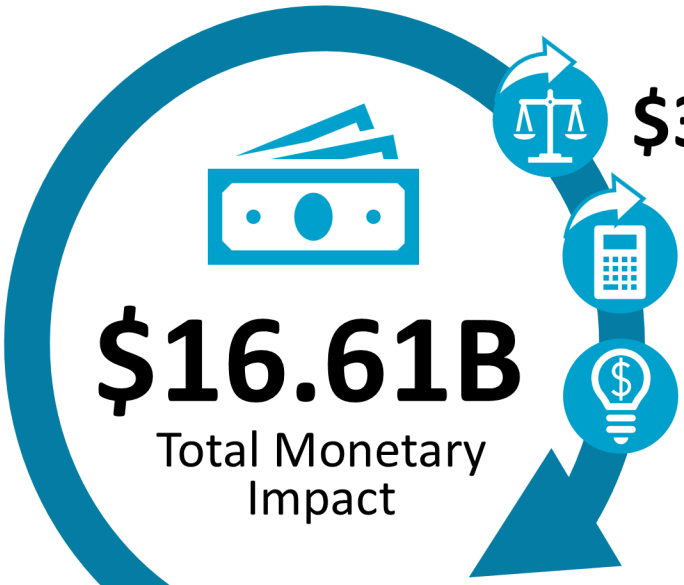
At a Glance:

OIG Accomplishments

October 1, 2024–March 31, 2025

OIG's work returns $11 in expected recoveries for every $1 invested.

MONETARY IMPACT*



$3.51B Investigative Receivables

$451M Audit Receivables

$12.65B Potential Cost Savings

Total Monetary Impact: The total amount of potential savings from investigative receivables, audit receivables, and recommendations that funds be put to better use.

Investigative Receivables: The monies ordered or agreed upon to be returned or paid to HHS or other Federal and State entities or private individuals because of OIG investigative activity that led to criminal actions, civil and administrative settlements, civil judgments, or administrative actions. It does not reflect actual collections.

Audit Receivables: The monies identified through OIG audits that the audited entity has sustained or formally agreed should not be charged to the Government. It does not reflect actual collections.

Potential Cost Savings: Represents funds put to better use which are funds that HHS could use more efficiently if it took action to implement our recommendations.

*Totals in appendices may differ slightly because of rounding.

At a Glance:

OIG Accomplishments

October 1, 2024–March 31, 2025

OVERSIGHT ACTIVITIES

78

Reports Issued: The number of reports OIG published, including audit reports, evaluation reports, and reports of findings in response to Office of Special Counsel whistleblower disclosures.

946

Investigations Closed: The number of closed OIG criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations.

165

Recommendations Issued: The number of actionable recommendations, based on data-driven findings, that OIG provided to HHS and that if implemented can result in both monetary and nonmonetary benefits.

290

Recommendations Implemented: The number of recommendations implemented by HHS and others can result in substantial savings and can also result in improvements to HHS programs.

ENFORCEMENT ACTIONS

1,503

Excluded Individuals and Entities: The number of untrustworthy individuals and entities OIG excluded from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal health care programs for any items or services they furnish, order, or prescribe.

1,209

Referrals: The number of OIG subjects presented to Federal, State, or local prosecuting jurisdictions for prosecutorial consideration.

349

Criminal Actions: The number of criminal actions, such as convictions, that occur once an individual or entity's guilt is determined and a sentence is imposed, or when a defendant enters a pretrial diversion program.

298

Criminal Informations and Indictments: The number of OIG informations and indictments—instances in which a formal accusation of a crime is made against an individual or entity by a grand jury or prosecuting attorney.

395

Civil Actions: The number of civil actions, including civil settlements and civil judgments, including actions resulting from the use of OIG's Civil Monetary Penalties Law authority.

Introduction

The Inspector General Act of 1978 (codified at 5 U.S.C. chapter 4), as amended, requires that the Inspector General report semiannually to the head of the Department of Health and Human Services (HHS or the Department) and to Congress on the activities of the Office of Inspector General (OIG). This semiannual report is intended to keep the Secretary and Congress fully informed of significant oversight work completed during the reporting period (October 1, 2024–March 31, 2025).

OIG's report on *Top Management and Performance Challenges Facing HHS* describes five areas with management challenges:

1) Public Health
2) Financial Integrity
3) Medicare and Medicaid
4) Beneficiary Safety
5) Data and Technology Security

The summaries of OIG's work in this semiannual report are organized around these areas. The report identifies key findings, information, and recommendations that could help the Department address these management challenges and fulfill its mission to enhance the health and well-being of all Americans.

In addition to highlighting significant work, this report includes a comprehensive overview of all of OIG's work completed in this semiannual reporting period. This detailed information can be found in the appendices that provide information on OIG's oversight, including a full list of OIG audits and evaluations issued to each HHS Operating Division during the reporting period.

Additional Resources

OIG's website contains the full breadth of OIG's oversight and enforcement work outside of this reporting period, including all reports available by issue area and HHS agency; OIG recommendations to improve Department programs and reduce vulnerabilities, including the status of those recommendations and those OIG has identified as top unimplemented recommendations; and OIG enforcement actions.

Additional information on OIG's positive financial impact on Medicare and Medicaid can be found in the annual Health Care Fraud and Abuse Control Program Report.

1 | Public Health

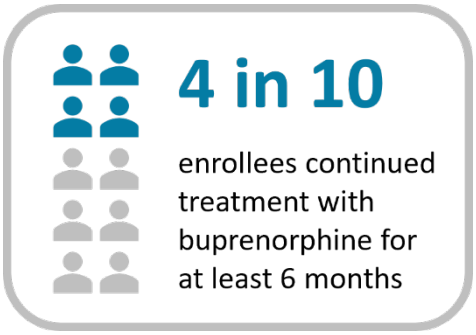
Opioid Epidemic

Combating the overdose crisis continues to be an important national priority, with nearly 55,000 opioid-related overdose deaths in 2024. In response, OIG takes action to advance prevention, detection, and enforcement of fraud, waste, and abuse in HHS programs that intersect with the opioid epidemic and help ensure quality care and treatment for those in need of services. Significant OIG work completed during this reporting period is detailed below.

- **ENFORCEMENT ACTION: McKinsey Agreed To Pay $650 Million To Resolve Allegations That It Advised Purdue Pharma L.P. To Submit Fraudulent Claims**

  To resolve allegations brought by OIG and our law enforcement partners, McKinsey & Company (McKinsey), a global management consulting firm, agreed to pay $650 million to resolve civil and criminal liabilities for the firm's consulting work with opioid manufacturer Purdue Pharma L.P. (Purdue). McKinsey advised Purdue on its strategy to market OxyContin to prescribers, including advising Purdue to "turbocharge" sales of OxyContin. McKinsey entered into a False Claims Act settlement to resolve allegations that McKinsey's advice caused the submission of fraudulent claims to Federal health care programs for Oxycontin that was not for a medically accepted indication. The resolution marks the first time a management consulting firm has been held criminally responsible for advice resulting in the commission of a crime by a client. McKinsey entered a 5-year deferred prosecution agreement with the Department of Justice and agreed to pay fines and forfeiture to resolve criminal misdemeanor misbranding and felony obstruction of justice charges. McKinsey also entered into a 5-year corporate integrity agreement with OIG.

Treatment Access



OIG found that not all Medicare enrollees continue treatment for opioid use disorder. About 40 percent of Medicare enrollees who started substance use disorder treatment with buprenorphine in 2021 or 2022 continued treatment. In the study period, enrollees who continued treatment were less likely to die compared with those who did not continue treatment. Additionally, just one-third of enrollees who started buprenorphine received at least one behavioral therapy service. Those who did not receive any behavioral health services were less likely to continue treatment. Finally, the Centers for Medicare & Medicaid Services (CMS) added new Medicare payments aimed, in part, at helping enrollees stay in treatment for opioid use disorder; however, OIG found that few enrollees received services billed to Medicare under these payments (OEI-02-23-00360).

OIG also found that a website intended to assist individuals in finding treatment for substance use and mental health disorders, FindTreatment.gov, contained some inaccurate information, such as facility addresses and services information (e.g., incorrect treatment approaches offered). OIG estimated that 14,283 of 22,106 facilities had inaccurately reported information (A-09-23-01003).

- **ENFORCEMENT ACTION:** **Addiction Treatment Center Owner Ordered To Pay More Than $3.5 Million for Fraud**

  OIG and law enforcement partners' work led to the conviction of a defunct owner of a chain of addiction treatment centers. An owner and operator of addiction treatment centers described as "drive-by" clinics, was sentenced to 98 months in prison followed by 3 years of supervised release and was ordered to pay restitution in the amount of $3,515,100 and to forfeit approximately $1 million dollars. Under the guise of running recovery clinics that supposedly provided medical and therapy services, the owner and operator provided patients with little to no therapy or support while billing Medicare and other insurers for full services. For example, the owner and operator and an addiction treatment center billed the Government or insurance providers for 45-minute sessions when, in fact, patients were seen for less than 15 minutes, and in some cases substantially less than that.

Drug and Medical Device Safety

The Food and Drug Administration (FDA) regulates crucial consumer products, including human and veterinary drugs and medical devices, and works to ensure the safety, effectiveness, quality, security, and availability of these products. In recent years, OIG has conducted a wide variety of work assessing the effectiveness of FDA approval, inspection, and postmarket surveillance processes. Significant OIG work completed during this reporting period is detailed below.

Drug Approvals

OIG concluded that FDA's use of its accelerated approval pathway raised concerns in 3 of 24 drugs reviewed. The accelerated approval pathway can speed development and review of new drugs to treat serious and life-threatening conditions; however, there is a risk that an accelerated approval drug will not ultimately provide a clinical benefit for patients. OIG identified instances in which FDA: (1) approved drugs despite concerns from its own reviewers and/or advisory panels, (2) deviated from recommended practices by evaluating analyses not included in the sponsor's original plan, and (3) did not properly document meetings held during the review process. Two of the three drugs that raised concerns are now off the market, and completion of the confirmatory trial for the third drug has been delayed (OEI-01-21-00400).

- **ENFORCEMENT ACTION:** **Magellan Ordered To Pay $42 Million for Concealing Device Malfunction**

  OIG and law enforcement partners' work resulted in Magellan Diagnostics, Inc. (Magellan), a medical device company, being ordered to pay a $21.8 million fine, $10.9 million in forfeiture, and a minimum of $9.3 million to compensate victims. Magellan was criminally charged for the concealment of a medical device malfunction that produced inaccurately low lead test results for tens of thousands of children and other patients. Specifically, Magellan failed to notify FDA about serious malfunctions in its LeadCare Ultra and LeadCare II testing devices.

2 | Financial Integrity

Ensuring sound stewardship of HHS funds that provide critical health and human service programs is paramount. OIG works to ensure the financial integrity of HHS funds through its oversight activities, which include preventing fraud, waste, and abuse; identifying improper payments; and identifying opportunities for cost savings. OIG also works to control costs by ensuring prudent payments in programs such as Medicare and Medicaid.

Improper Payments

Effects of Improper Payments
Improper payments duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules.

An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. This includes payments made to ineligible recipients, for ineligible or duplicate goods or services, or for goods or services not received (unless authorized by law). It also includes unauthorized payments, such as those not allowable under a contract or grant. OIG uses its advanced data analytics capacity to aid in the sound stewardship of Department funds and to combat fraud, waste, and abuse in HHS programs. Significant OIG work completed during this reporting period is detailed below.

OIG found that CMS made millions of dollars of inappropriate drug payments causing the Federal Government and taxpayers to incur unnecessary costs. Medicare Part D does not cover drugs for which payment is available under Part A. However, OIG found that Medicare Part D improperly paid up to an estimated $465 million for drugs for which payment was available under the Medicare Part A skilled nursing facility (SNF) benefit over a 3-year period (A-09-21-03008).

CMS improperly paid up to an estimated **$465M** for certain drugs

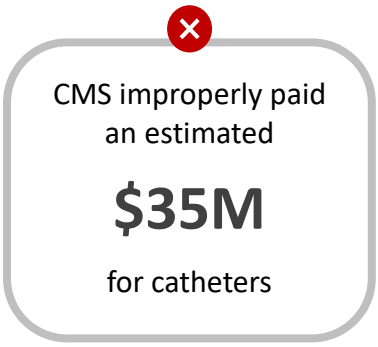
CMS may have improperly paid up to **$454M** for COVID-19 tests

OIG found that CMS may have made millions of dollars of potentially inappropriate payments for COVID-19 tests, the costs of which are borne by the Federal Government and taxpayers. From April 2022 through May 2023, CMS paid for up to eight over-the-counter COVID-19 tests per month for Medicare enrollees. However, OIG found that Medicare may have paid up to $454 million in potentially improper payments to providers for nearly 39 million over-the-counter COVID-19 tests in excess of the monthly limit of eight tests per enrollee (A-06-23-06000).

OIG found that CMS made millions of dollars of improper payments to acute-care hospitals. CMS made these payments for outpatient services for hospice enrollees that were already covered as part of the hospices' per diem payments. These services should have been provided directly by the hospices or under arrangements between the hospices and acute-care hospitals. OIG estimates that Medicare could have saved $190 million over 5 years if payments had not been made improperly. In addition, OIG estimates that enrollees could

CMS improperly paid an estimated **$190M** for outpatient services

have saved nearly $44 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf (A-09-23-03024).



OIG found that from July 2021 through June 2022, CMS made millions of dollars of inappropriate payments for catheters, the costs of which are borne by the Federal Government and enrollees. CMS has consistently identified high improper payments for urological supplies such as catheters. OIG estimates that of the more than $303 million Medicare paid for catheters and kits, approximately $35 million was improperly paid. In addition, OIG estimates that enrollees were responsible for nearly $9 million in associated coinsurance. OIG analyzed claims submitted after our audit period and found a substantial increase, which may indicate improper claims. Specifically, in 2023, suppliers billed 125,426 claims for providing female enrollees a more expensive type of catheter. In comparison, suppliers billed only 2,753 claims for that type of catheter provided to female enrollees during our audit period (A-09-22-03019).

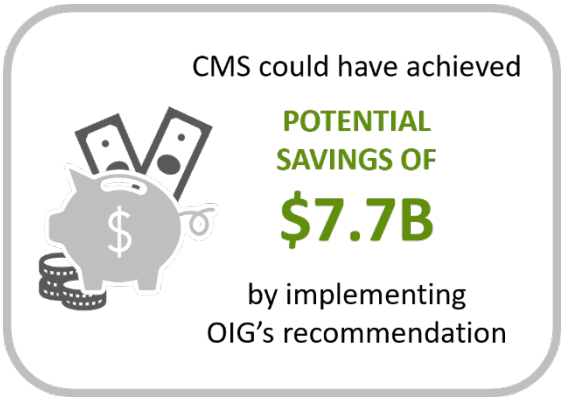
OIG found that the Administration for Children and Families (ACF) did not award and monitor the Deloitte Consulting LLP (Deloitte) contract in accordance with Federal requirements. ACF awarded a $301,747 sole source contract to Deloitte and subsequently modified the contract 12 times, increasing the value of the contract to $19.4 million for a 9-month period of performance. ACF paid $5 million for potentially unallowable costs and may have violated the Antideficiency Act by paying $1.5 million for services outside the period of performance (A-12-22-10000).

Cost-Effectiveness

OIG's oversight identifies cost-saving opportunities, promotes efficient and effective ways to address costs, and ensures good financial stewardship by recommending program improvements. Significant OIG work completed during this reporting period is detailed below.

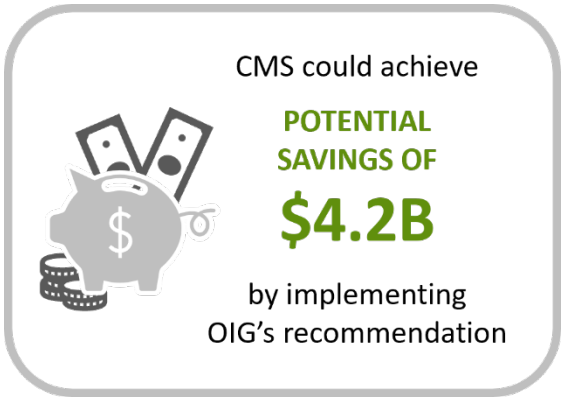
Critical Access Hospital Reimbursement Rates

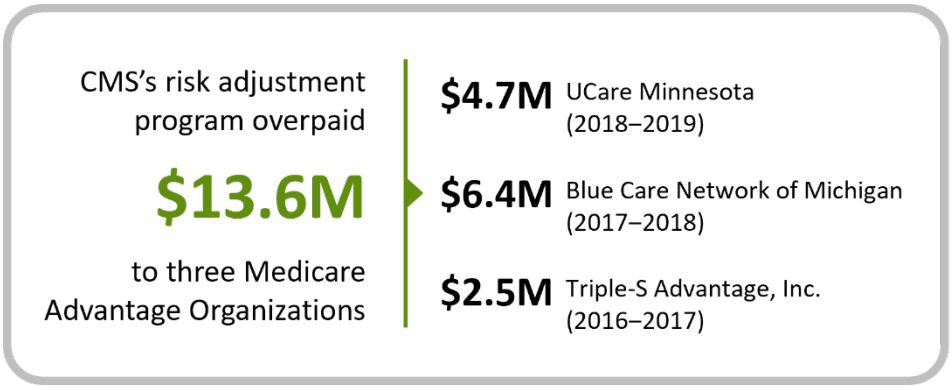
OIG estimates that Medicare could have saved $7.7 billion with comparable access for enrollees if Critical Access Hospital (CAH) payments for swing-bed services (which are similar to services performed at SNFs) were similar to those of the fee-for-service prospective payment system. As in 2015, OIG again recommended that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities (A-05-21-00018).



Medicare Advantage Risk-Adjusted Payments

CMS's risk adjustment program pays Medicare Advantage organizations more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources. OIG found that billions of estimated risk-adjusted payments to Medicare Advantage companies supported solely through health risk assessments (HRAs) and chart reviews linked to HRA visits continue to raise concerns about the validity of diagnoses on HRAs and the quality-of-care coordination for enrollees. Together, in-home HRAs and the subset of chart reviews that relied on in-home HRAs generated an estimated $4.2 billion of the total $7.5 billion in risk-adjusted payments. OIG recommended that CMS impose additional restrictions on the use of diagnoses reported only on in-home HRAs or chart reviews that are linked to in-home HRAs for risk-adjusted payments (OEI-03-23-00380). OIG also found $13.6 million in estimated net overpayments through three audits of high-risk diagnosis codes that Medicare Advantage organizations submitted to CMS for use in its risk adjustment program (A-07-22-01209, A-06-20-02000, A-04-21-07095).





Reducing Drug Spending

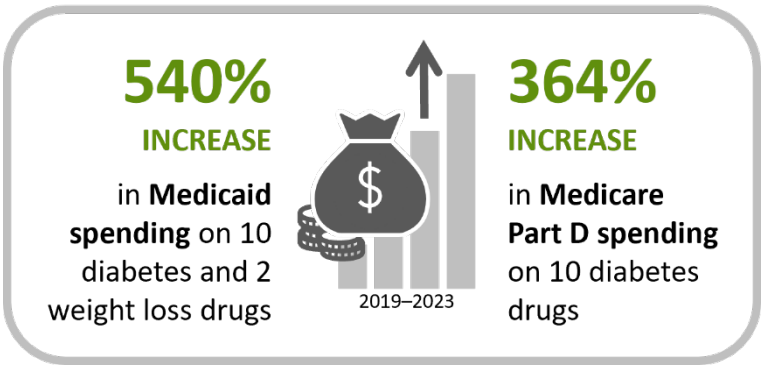
The United States, including Medicare and Medicaid, spent nearly $450 billion on prescription drugs in 2023. In an effort to protect these programs and their enrollees from paying excessive amounts for needed prescription drugs, OIG has a large body of mandated and other work focused on Medicare and Medicaid maximizing economy in the purchase of prescription drugs. Significant OIG work completed during this reporting period is detailed below.

Utilization Data for Part B Coverage Determination of Stelara

OIG found that Medicare Administrative Contractors' (MACs') challenges with utilization data when determining Part B coverage could lead to excluding drugs from Part B coverage inappropriately, potentially leading to higher costs to Medicare and its enrollees. Specifically, MACs face challenges with utilization data when following CMS's coverage guidance for drugs such as Stelara, a high-cost prescription biologic approved to treat certain autoimmune diseases (OEI-BL-19-00501).

Spending on Diabetes and Weight Loss Drugs

OIG examined national Medicaid gross spending on certain diabetes and weight loss drugs. OIG found that Medicaid gross spending on 10 selected diabetes and 2 selected weight loss drugs totaled more than $9 billion in 2023, an increase of 540 percent from 2019. If spending continues to grow at similar rates, Medicaid could potentially spend more than $29 billion on these drugs in 2026 (A-05-24-00016). OIG also found that Medicare Part D spending for 10 selected diabetes drugs totaled $35.8 billion in 2023, an increase of 364 percent from 2019. If spending continues to grow at similar rates, Medicare Part D could potentially spend more than $102 billion on these drugs in 2026 (A-05-24-00015).



3 | Medicare and Medicaid

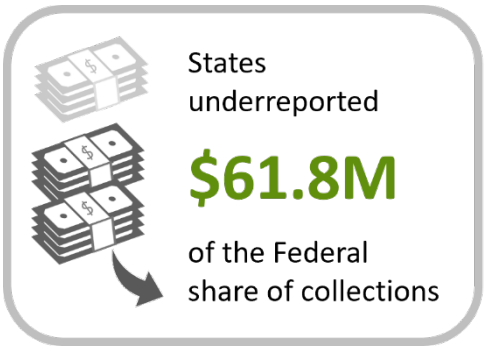
Program Integrity

In fiscal year (FY) 2024, CMS administered the $839 billion Medicare program to approximately 68 million enrollees and administered the $584 billion Medicaid program, including the Children's Health Insurance Program, to approximately 73 million enrollees. OIG's oversight of these funds ensures program integrity by preventing fraud, ensuring that HHS funds are managed effectively and efficiently and that quality services and health care are delivered to eligible Americans. Significant OIG work completed during this reporting period is detailed below.

- **ENFORCEMENT ACTION: Independent Health Agreed To Pay At Least $34.5 Million for Inflating Medicare Risk Adjustment Payments**
  OIG and law enforcement partners' work resulted in Independent Health Association and its subsidiaries, Independent Health Corporation and DxID (collectively, Independent Health), agreeing to pay $34.5 million with contingent payments of up to $63.5 million. These payments are to resolve allegations that Independent Health violated the False Claims Act by knowingly submitting or causing the submission of invalid diagnosis codes to Medicare for Medicare Advantage Plan enrollees to increase payments that Independent Health received from Medicare.

Returning Federal Share of Medicaid Collections

OIG found that some States were underreporting the Federal share of collections made. For example, 12 of the 13 selected States underreported the Federal share of collections by a net $61.8 million because they did not use the correct Federal Medical Assistance Percentage or made calculation errors. Underreporting the Federal share of collections means States do not return to the Federal Government everything it is owed (A-06-23-09002).



Medicaid Payments for Autism Services

OIG found that Indiana did not comply with fee-for-service requirements that could have a significant effect on the quality of care provided to children diagnosed with autism. Specifically, OIG found that Indiana's payments for applied behavior analysis, a commonly used therapy for managing autism symptoms, did not fully comply with Federal and State requirements. For example, improper or potentially improper payments were associated with services for which documentation requirements were not met or session notes were not detailed. Additionally, because some services were provided by staff who did not have appropriate credentials, children with autism may not have received the quality of care they needed (A-09-22-02002).

Hospital Price Transparency

OIG estimates that 46 percent of the 5,879 hospitals that were required to comply with the Hospital Price Transparency rule did not. Select hospitals are required to make information on their standard charges available to the public. The hospitals that failed to comply did not publish comprehensive machine-readable

files and/or did not display shoppable services in a consumer-friendly manner. CMS and others believe that price transparency can increase market competition and drive down the cost of health care services (A-07-22-06108).

Health Care Fraud

OIG is the leading Federal agency focused on combating health care fraud. Investigators work in every State and actively coordinate with the Department of Justice and other Federal, State, Tribal, and local law enforcement agencies. Investigations, sometimes generated through hotline referrals, often lead to criminal convictions, administrative sanctions, exclusion, or civil monetary penalties. Significant OIG work completed during this reporting period is detailed below.

OIG Hotline

OIG's hotline accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. During the reporting period, OIG evaluated and processed nearly 31,000 tips leading to 17,000 referrals to entities such as OIG's investigative and legal branches, HHS operating divisions, and other federal agencies. Additionally, during the reporting period, cases that were previously initiated through hotline complaints resulted in 34 criminal and civil actions associated with expected recoveries of approximately $121 million. Learn more here.

- **ENFORCEMENT ACTION:** **Home Health Care Operator Ordered To Pay Nearly $100 Million for Role in Fraud Scheme**

  OIG and law enforcement partners' work led to the conviction of an operator of a home health care company for her part in a $100 million home health care fraud scheme. The operator was sentenced to 12 years in prison followed by 3 years of supervised release and was ordered to pay restitution in the amount of $99,734,517 and a fine of $250,000. Specifically, the owner and others conspired to use Arbor Homecare Services LLC to bill MassHealth for home health services that were never provided and paid kickbacks for patient referrals, regardless of medical necessity. They also entered sham employment relationships with patients' family members to provide home health aide services that were not medically necessary.

- **ENFORCEMENT ACTION:** **Doctor Sentenced to 10 Years in Prison and Ordered To Pay $34 Million in Restitution**

  OIG and law enforcement partners' work led to a Texas doctor being sentenced to 10 years in prison and ordered to pay more than $34 million for his role in a scheme to defraud Medicare by prescribing durable medical equipment and cancer genetic testing without seeing, speaking to, or treating patients. The doctor received more than $466,000 in kickbacks for signed doctor's orders that were used to submit more than $54 million in false and fraudulent claims to Medicare.

- **ENFORCEMENT ACTION:** **Telemarketer Sentenced for $67 Million Health Care Fraud and Money Laundering Scheme**

  OIG and law enforcement partners' work resulted in a telemarketer being sentenced to 15 years in prison

for his role in a conspiracy to defraud Medicare by billing more than $67 million for medically unnecessary genetic testing. The telemarketer, who managed a call center, contacted the primary care physicians of targeted Medicare beneficiaries and tricked these medical providers into ordering medically unnecessary genetic tests based on medical paperwork that the call center created. The telemarketer and his co-conspirators then used these doctors' orders to submit claims to Medicare for tests, the results of which were often not sent to the physicians or used for treating patients.

ENFORCEMENT ACTION: **MMM Holdings, LLC, To Pay $15.2 Million for a Fraudulent Gift Card Incentive Program**

OIG and law enforcement partners' work resulted in MMM Holdings, LLC (MMM), a managed care organization, agreeing to pay $15.2 million to resolve allegations that it violated the False Claims Act by paying kickbacks for the referral of new Medicare Advantage plan enrollees. According to the settlement, MMM allegedly distributed gift cards to administrative assistants of providers to induce the referral, recommendation, or arrangement for enrollment of thousands of Medicare beneficiaries in an MMM Medicare Advantage plan. In addition to the settlement, MMM entered into a 5-year corporate integrity agreement with OIG.

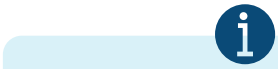
Special Fraud Alert

Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers

OIG issued a Special Fraud Alert that warns Medicare Advantage organizations, health care professionals, agents and brokers, and others about certain marketing schemes involving the Medicare Advantage program. These schemes involve questionable payments and referrals between Medicare Advantage plans, health care professionals, and third-party marketers such as agents and brokers. These schemes can mislead Medicare enrollees into choosing specific health plans or health care providers that may not meet the enrollees' needs.

ENFORCEMENT ACTION: **Pharmacy Owner Sentenced and Excluded for Kickback Scheme**

OIG excluded a Texas pharmacy owner from participation in all federally funded health care programs for 50 years. The pharmacy owner worked with others to create and market expensive compounded medications and paid marketers to recruit physicians to prescribe these drugs, engaging in an extensive kickback scheme that defrauded Federal health programs. The pharmacy owner was found guilty of four counts of payment and receipt of kickbacks and one count of conspiracy to launder monetary instruments. He was sentenced to 52 months in prison and ordered to pay approximately $59 million in restitution to Medicare and other Government health care programs.

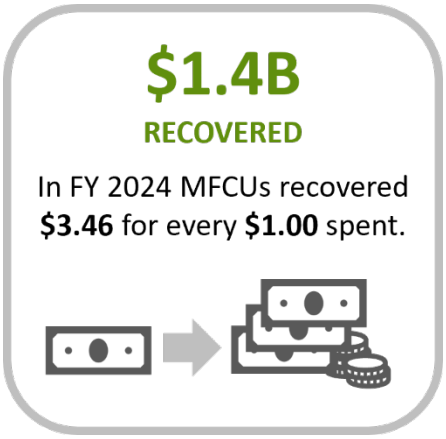


OIG's Exclusion Authority

OIG has the authority to exclude individuals and entities from participation in Federal health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded cannot receive payment from Federal health care programs for any items or services they furnish, order, or prescribe.

Medicaid Fraud Control Units

OIG administers grants that provide Federal funding to Medicaid Fraud Control Units (MFCUs) to fight Medicaid fraud and protect nursing home patients from abuse. In FY 2024, MFCU work resulted in 1,151 convictions, 1,042 exclusions from federally funded programs, 493 civil settlements and judgments, and $1.4 billion recovered. For additional information, see the FY 2024 MFCU Annual Report (OEI-09-25-00090). Additionally, OIG works with MFCUs as State-based law enforcement partners. During the reporting period, OIG and MFCUs worked together on 975 joint investigations that resulted in 86 civil actions or Civil Monetary Penalties Law outcomes and 117 criminal adjudications.



4 | Beneficiary Safety

Abuse and Neglect

Many HHS beneficiaries, such as children and nursing home residents, are vulnerable to abuse and neglect, which can have a long-term impact on their health and well-being. OIG works to protect these beneficiaries in many ways, including investigating specific cases and conducting reviews to examine compliance with program requirements intended to enhance beneficiary safety and protect patient rights. Significant OIG work completed during this reporting period is detailed below.

- **ENFORCEMENT ACTION:** **Medicaid Caregiver Excluded for 31 Years for Causing Bodily Injury**
  OIG excluded a caregiver from participation in Federal Government health care programs for a minimum of 31 years following her conviction for causing serious bodily injury to her daughter, a 28-year-old Medicaid recipient who suffered from cerebral palsy and had the mental development of an 11-month-old child. The caregiver was excluded for failure to provide appropriate care. She was also sentenced to 20 years in prison.

- **ENFORCEMENT ACTION:** **Nursing Home Owner Excluded for 27 Years for Abuse and Fraud**
  OIG excluded a nursing home owner from participation in federally funded health care programs for 27 years based on his conviction of eight counts of cruelty to the infirm, five counts of Medicaid fraud, and two counts of obstruction of justice. The nursing home owner was also ordered to pay $358,000 in restitution for the pain and neglect caused to eight patients as a result of his failure to provide basic, adequate, and essential care to them during Hurricane Ida in 2021.

- **ENFORCEMENT ACTION:** **Pharmacy Owner Sentenced for Predatory HIV Medication Scheme**
  OIG and law enforcement partners' work led to a former pharmacy owner being sentenced to 2–6 years in prison for a predatory scheme that stole millions of dollars from Medicaid and preyed on low-income patients with HIV who needed life-saving medications. The pharmacy owner and his associates paid illegal kickbacks to patients to ensure that these patients would use the more than 20 pharmacies they owned. The pharmacies then filled their prescriptions with unsafe medications illegally purchased from the black market or other pharmacy patients.

Child Abuse and Neglect Reporting

OIG found that Maine did not comply with child abuse and neglect screening, assessment, and investigation requirements in response to reports of abuse and neglect. OIG estimates that 94 percent of Maine's child abuse and neglect reports reviewed did not comply with one or more of these requirements (A-01-23-02500).

94%
of Maine's child abuse and neglect reports were not in compliance

5 | Data and Technology Security

Cybersecurity

HHS faces persistent cybersecurity threats that exacerbate the challenges associated with data and technologies used to carry out the Department's vital health and human services missions. OIG conducts oversight of the cybersecurity of data and information systems that store critical and potentially sensitive data, such as organ procurement and transplant data and other electronic health information. Significant OIG work completed during this reporting period is detailed below.

Lacking Adequate Security Controls To Mitigate Risk of a Cybersecurity Compromise

OIG found that from 2018 through 2020, eight HHS Operating Divisions lacked adequate protections to mitigate cybersecurity risks. Specifically, OIG identified 19 threats during the time of our audits that had been active on servers and workstations and 138 vulnerabilities related to 19 National Institute of Standards and Technology Special Publication 800-53, Revision 4, controls that were not effectively implemented (A-18-22-07002).

Organ Procurement and Transplantation Network Monitoring Was Not Effective

OIG determined that from April 2023 to June 2023, it would likely have taken an attacker a moderate level of sophistication to be able to compromise the Organ Procurement and Transplantation Network information technology system or data and cause significant harm. OIG identified 22 vulnerabilities associated with 16 cybersecurity control weaknesses, mostly related to ineffective network monitoring. The vulnerabilities occurred because certain federally required cybersecurity controls had not been implemented or were not operating effectively to prevent, detect, or mitigate some of the simulated cyberattacks (A-18-22-03400).

HHS Not Effectively Assessing Electronic Health Information Security

OIG found that from January 2016 to December 2020, the Office of Civil Rights (OCR) fulfilled its requirement under the Health Information Technology for Economic and Clinical Health Act to perform periodic Health Insurance Portability and Accountability Act of 1996 (HIPAA) audits. However, OCR's HIPAA audit implementation was too narrowly scoped to effectively assess safeguards of electronic protected health information and demonstrate a reduction of risks within the health care sector. Additionally, OCR oversight of its HIPAA audit program was not effective at improving cybersecurity protections for covered entities and business associates (A-18-21-08014).

- **ENFORCEMENT ACTION: Lab Technician Excluded and Sentenced for Health Care Fraud and Identity Theft**

  OIG excluded a lab technician from participation in federally funded health care programs for a minimum of 27 years for health care fraud and aggravated identify theft. The lab technician and co-conspirators submitted false claims to multiple health care plans for COVID-19 testing services using stolen personally identifiable information. The lab technician admitted that he accessed private patient information, including names, dates of birth, and insurance subscriber numbers, through the various clinics where he

worked and then used the patient information to submit claims to insurance providers for COVID-19 testing services that were never performed. The lab technician was also sentenced to 84 months in prison and ordered to pay restitution of approximately $7 million.

- **ENFORCEMENT ACTION:** **Contractor Settled False Claims Act Liability for Failure To Secure Medicare Enrollee Data**

  OIG and law enforcement partners' work led to ASRC Federal Data Solutions LLC (AFDS), a contractor that provided Medicare support services, paying a $306,000 settlement to resolve False Claims Act allegations that it and a subcontractor failed to secure Medicare enrollee data. According to the settlement, AFDS allegedly stored screenshots from CMS systems containing personally identifiable information and potentially protected health information of Medicare beneficiaries without individually encrypting the files to protect them against exposure in the event of a breach.

OIG Impact From Recommendations

October 1, 2024–March 31, 2025

In keeping with the mandates of the Inspector General Act and to drive positive change, OIG provides HHS with data-driven findings and actionable recommendations. OIG-issued recommendations, when implemented, result in both monetary and nonmonetary benefits. The recommendations issued during this reporting period could potentially save $12.84 billion by identifying $12.65 billon in funds put to better use and $189 million in questioned costs.

RECOMMENDATIONS ISSUED

90	Preventing, detecting, and deterring fraud, waste, and abuse
20	Fostering sound financial stewardship and reducing improper payments
5	Holding wrongdoers accountable and recovering misspent public funds
9	Fostering quality, safety, and value of HHS-funded services
26	Promoting public health and safety
15	Supporting high-performing health and human services programs

OIG issued

165

recommendations that could potentially save

$12.84B

if implemented

RECOMMENDATIONS IMPLEMENTED

128	Preventing, detecting, and deterring fraud, waste, and abuse
35	Fostering sound financial stewardship and reducing improper payments
7	Holding wrongdoers accountable and recovering misspent public funds
23	Fostering quality, safety, and value of HHS-funded services
44	Promoting public health and safety
53	Supporting high-performing health and human services programs

HHS and non-HHS entities implemented

290

recommendations that saved

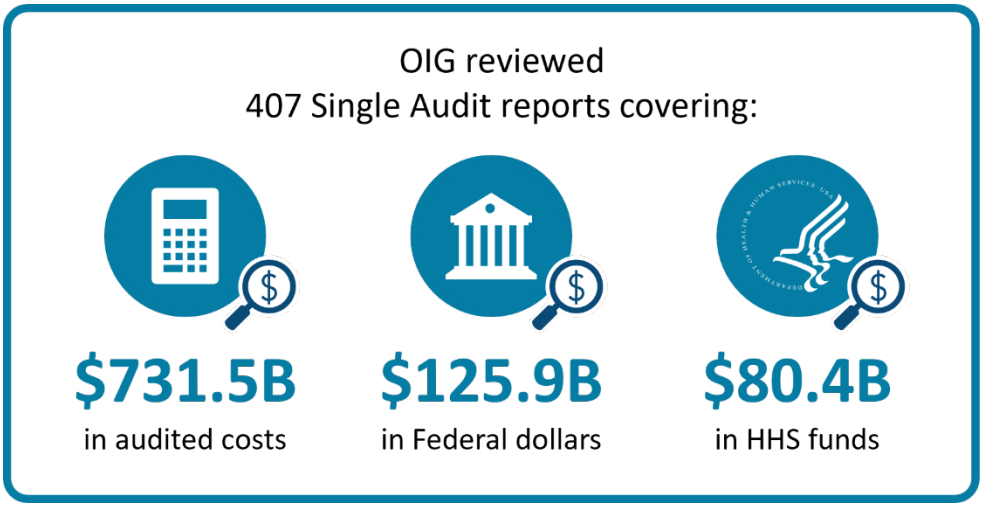
$1.77B

Additional OIG Activities

Single Audits

OIG conducts oversight of Single Audits—organizationwide audits of non-Federal entities' financial statements and expenditures of Federal awards—to monitor how recipients are using Federal funds for HHS programs. By working to improve the quality of Single Audits, OIG provides assurance to the public that taxpayer dollars are being safeguarded and spent for their intended purposes, resulting in millions of Americans receiving improved health care and human services. See below for the number of Single Audits OIG reviewed during the reporting period, as well as the amounts those Single Audits covered. Read more on OIG's Single Audits website.

Single Audits (October 1, 2024–March 31, 2025)



Whistleblower Retaliation

OIG investigated and substantiated three complaints from whistleblowers who reported wrongdoing associated with HHS-funded programs and services and were retaliated against because of it. Read more about these complaints here and more about OIG's Whistleblower Protection Coordinator role here.

Safe Harbor Proposals

OIG annually solicits proposals for developing new and modifying existing safe harbors to the Federal anti-kickback statute, section 1128B(b) of the Social Security Act, and for developing special fraud alerts. In November 2024, OIG published its annual solicitation in the *Federal Register*. OIG received seven proposals during the reporting period, all of which are still under review as of March 31, 2025. For information about the proposals received in response to the 2023 annual solicitation and OIG's response to those proposals, see Appendix D in OIG's Fall 2024 Semiannual Report to Congress.

Appendix A: Audits and Evaluations

The following table summarizes OIG's audit and evaluation reports issued during the reporting period, including, if applicable, the associated questioned costs, funds put to better use, unsupported costs, and whether a management decision was made during the reporting period.[1] During the reporting period, OIG identified **$189 million in questioned costs**, **$12.65 billion in funds put to better use**, and **$27 million in unsupported costs**. See Appendix B for more detail about reports with questioned costs and funds put to better use. Note that OIG has not yet received management decisions for most reports listed below because those decisions are not due to OIG until 6 months following the issuance of a report.

DEFINITIONS

As defined by the Inspector General Act, the term **"questioned cost"** means a cost that is questioned by OIG because of: (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, the cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.

Funds put to better use are funds that could be used more efficiently if management took actions to implement and complete the recommendation, through reductions in outlays, de-obligation of funds, and/or avoidance of unnecessary expenditures.

Unsupported costs are a subset of questioned costs; these are costs that OIG found that, at the time of the audit, are not supported by adequate documentation.

A **final management decision** is a final decision by management concerning its response to the findings and recommendations included in an audit report, including actions concluded to be necessary.

[1] OIG did not issue any nonpublic audit or evaluation reports during the reporting period.

Table 1: Audit and Evaluation Reports Issued (October 1, 2024–March 31, 2025)

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Administration for Children and Families (ACF)				
Maine Did Not Comply With Screening, Assessment, and Investigation Requirements for Responding to Reports of Child Abuse and Neglect (A-01-23-02500), November 2024	-	-	-	-
ACF Used Contractor Personnel To Perform Inherently Governmental Functions and Paid Millions in Potentially Unallowable Costs (A-12-22-10000), February 2025*	$4,968,857	-	$4,968,857	Yes
Little Overlap Exists Between ORR-Funded Foster Care and the U.S. Domestic Foster Care System (OEI-07-24-00320), March 2025	-	-	-	-
Administration for Community Living (ACL)				
California Used CARES Act Funds for Unallowable Nutrition Services Program Expenditures (A-06-22-01004), October 2024	$3,572,090	-	$2,484,631	Yes
Administration for Strategic Preparedness and Response (ASPR)				
ASPR Established Adequate Controls for Maintaining Physical Security and Inventory Records at Stockpile Site B (A-04-24-02046), October 2024	-	-	-	-
Response to OSC File #DI-20-000743: HHS Actions Related to FDA's March 2020 Emergency Use Authorization for Chloroquine and Hydroxychloroquine (OEI-09-20-00571), December 2024	-	-	-	-
ASPR Established Adequate Controls for Maintaining Physical Security and Inventory Records at Stockpile Site C (A-04-24-02047), January 2025	-	-	-	-
Agency for Healthcare Research and Quality (AHRQ)				
Some HHS Requirements for Vetting Mobile Apps Were Not Followed Prior to the Release of the AHRQ Question Builder App (A-18-22-09008), December 2024	-	-	-	-
Centers for Disease Control and Prevention (CDC)				
CDC's and SAMHSA's Processes for and Challenges With Compiling Data for the National Drug Control Assessment (A-03-24-00353), November 2024	-	-	-	-
ICAP at Columbia University Generally Managed Its PEPFAR Expenditures Appropriately but Lacked a Robust Financial Management System (A-04-20-01020), December 2024	$58,111	-	-	-
Florida Generally Used CDC Public Health Crisis Response Cooperative Agreement Program Funds in Accordance With Federal Requirements (A-02-23-02008), February 2025	$218,504	-	-	-
CDC Lacked Documentation for Its Redirections of PEPFAR Funds To Support the COVID-19 Response (A-04-23-01028), February 2025	-	-	-	-
Centers for Medicare & Medicaid Services (CMS)				
Massachusetts Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (A-01-23-00003), October 2024	-	-	-	-
Medicare Part D Paid Millions for Drugs for Which Payment Was Available Under the Medicare Part A Skilled Nursing Facility Benefit (A-09-21-03008), October 2024	$953,370	$465,077,908	-	Yes

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Massachusetts Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Emergency Preparedness (A-01-24-00001), October 2024	-	-	-	Yes
National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers (A-06-24-05000), October 2024	-	-	-	Yes
Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions (OEI-03-23-00380), October 2024	-	$4,194,145,137	-	-
Not All Selected Hospitals Complied With the Hospital Price Transparency Rule (A-07-22-06108), November 2024	-	-	-	Yes
Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2024 (A-17-24-53000), November 2024	-	-	-	-
Utah Generally Operated Its Medicaid Estate Recovery Program in Accordance With Requirements and in a Cost-Effective Manner, but Utah Did Not Have Formal Written Procedures (A-07-23-03257), November 2024	-	-	-	Yes
Medicare Improperly Paid Acute-Care Hospitals an Estimated $190 Million Over 5 Years for Outpatient Services Provided to Hospice Enrollees (A-09-23-03024), November 2024	-	$190,110,930	-	Yes
Washington State's Oversight Could Better Ensure That Adult Family Homes Comply With Health and Safety and Administrative Requirements (A-09-23-02002), November 2024	-	-	-	Yes
Puerto Rico Did Not Designate a Medicaid Contracts Oversight Lead in a Timely Manner and Certified Contracts That Were Noncompliant (A-02-24-01002), November 2024	-	-	-	Yes
Texas Generally Claimed Medicaid Reimbursement for Fee-for-Service Inpatient Hospital Claims With Malnutrition Diagnosis Codes in Accordance With Federal and State Requirements (A-06-22-04002), November 2024	-	-	-	-
CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020 (A-06-23-09003), November 2024	-	-	-	Yes
National Background Check Program for Long-Term Care Providers: A Final Assessment (OEI-07-24-00100), November 2024	-	-	-	-
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Second Quarter of 2024 (OEI-03-25-00010), November 2024	-	-	-	-
Nonprofit and Government-Owned Nursing Homes Generally Complied With Federal Requirements Regarding the Infection Preventionist Position (A-01-24-00002), December 2024	-	-	-	Yes
Medicaid Gross Spending on 10 Selected Diabetes and 2 Selected Weight Loss Drugs Totaled More Than $9 Billion in 2023, an Increase of 540 Percent From 2019 (A-05-24-00016), December 2024	-	-	-	-
Twelve Selected States Did Not Accurately Calculate the Federal Share of Medicaid Collections Subject to the Increased COVID-19 Federal Medical Assistance Percentages (A-06-23-09002), December 2024	$61,792,714	-	-	-
Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism (A-09-22-02002), December 2024	$39,432,556	$53,236,026	-	Yes

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs (A-07-21-02836), December 2024	-	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Triple-S Advantage, Inc. (Contract H5774) Submitted to CMS (A-04-21-07095), December 2024	$296,758	-	-	Yes
Providers Used Medicare Part D Eligibility Verification Transactions for Permissible Purposes (A-05-22-00022), December 2024	-	-	-	-
Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health (A-05-23-00017), December 2024	$6,046	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes Blue Care Network of Michigan (Contract H5883) Submitted to CMS (A-06-20-02000), December 2024	$3,412,369	-	-	Yes
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UCare Minnesota (Contract H2459) Submitted to CMS (A-07-22-01209), December 2024	$4,761,271	-	-	Yes
Florida Did Not Comply With Federal Waiver and State Requirements at 18 of 20 Adult Day Care Facilities Reviewed (A-04-23-00135), December 2024	-	-	-	-
Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System (A-05-21-00018), December 2024	-	$7,710,443,385	-	-
Update: Xolair Prefilled Syringes Likely Meet Part B Coverage Criteria (OEI-BL-24-00440), December 2024	-	-	-	-
Total Medicare Part B Spending on Lab Tests Decreased in 2023, Driven in Part by Less Spending on COVID-19 Tests (OEI-09-24-00350), December 2024	-	-	-	-
Wisconsin Medicaid Fraud Control Unit: 2024 Inspection (OEI-07-24-00220), January 2025				
Centers for Medicare & Medicaid Services Fiscal Year 2024 Detailed Accounting Submission and Fiscal Year 2026 Budget Formulation Compliance Report for National Drug Control Activities, and the Accompanying Required Assertions (OAS-25-03-018), January 2025	-	-	-	-
West Virginia Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs (A-07-23-06109), February 2025	$2,173,585	$488,185	-	-
Medicare Improperly Paid Suppliers for Intermittent Urinary Catheters (A-09-22-03019), February 2025	$11,399	$35,079,833	-	-
Colorado Made Capitation Payments to Managed Care Organizations After Enrollees' Deaths (A-07-21-05132), February 2025	$13,332,364	-	$7,320,166	-
Mental Health Center of Florida Generally Met Medicare Billing Requirements for Some Psychotherapy Services (A-04-21-06251), February 2025	-	-	-	-
Massachusetts Generally Claimed Safety Net Care Pool Costs That Complied With Federal Requirements (A-04-22-04091), February 2025	$41,768,735	-	-	-
Medicare Paid Claims That Were Not in Accordance With the Over-the-Counter COVID-19 Test Kits Demonstration Quantity Limitation (A-06-23-06000), February 2025	-	-	-	-
Office of Inspector General's Partnership With the Office of the Washington State Auditor: State Auditor's Report Examining Washington's Concurrent Medicaid Enrollments (A-09-23-02009), February 2025	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Medicare Part D Spending for 10 Selected Diabetes Drugs Totaled $35.8 Billion in 2023, an Increase of 364 Percent From 2019 (A-05-24-00015), February 2025	-	-	-	-
Office of Inspector General's Partnership With the Commonwealth of Massachusetts, Office of the State Auditor: Office of Medicaid (MassHealth) — Review of Capitation Payments With Multiple Identification Numbers (A-01-23-00004), February 2025	-	-	-	-
Not All Medicare Enrollees Are Continuing Treatment for Opioid Use Disorder (OEI-02-23-00360), February 2025	-	-	-	-
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2024 (OEI-03-25-00020), February 2025	-	-	-	-
Medicare Contractors Did Not Use Complete and Timely Utilization Data When Making Part B Coverage Determinations for Stelara (OEI-BL-19-00501), February 2025	-	-	-	-
North Carolina's Medicaid Control Environment, Risk Management Practices, and Governing Processes Were Assessed as Moderate Risk (A-04-21-00127), March 2025	-	-	-	-
Texas Did Not Fully Comply With Federal Waiver and State Health, Safety, and Administrative Requirements at All 20 Adult Day Activity Health and Service Facilities Audited (A-06-23-05000), March 2025	-	-	-	-
Medicare Administrative Contractors Did Not Consistently Meet Medicare Cost Report Oversight Requirements (A-04-22-06264), March 2025	-	-	-	-
Medicare and Medicaid Payments to Providers Are at Risk of Diversion Through Electronic Funds Transfer Fraud Schemes (OEI-07-23-00180), March 2025	-	-	-	-
State Survey Agencies Need Additional Guidance To Assess Nursing Home Emergency Preparedness Programs (OEI-04-23-00030), March 2025	-	-	-	-
Medicaid Fraud Control Units Annual Report: Fiscal Year 2024 (OEI-09-25-00090), March 2025	-	-	-	-
Food and Drug Administration (FDA)				
How FDA Used Its Accelerated Approval Pathway Raised Concerns in 3 of 24 Drugs Reviewed (OEI-01-21-00400), January 2025	-	-	-	-
Health Resources and Services Administration (HRSA)				
Seven of Thirty Hospices Reviewed Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments (A-02-22-01014), November 2024	$12,273,544	-	$12,273,544	-
Selected Home Health Agencies Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments (A-01-22-00503), November 2024	-	-	-	-
The Organ Procurement and Transplantation Network IT System's Cybersecurity Controls Were Partially Effective and Improvements Are Needed (A-18-22-03400), December 2024	-	-	-	-
Health Resources and Services Administration Fiscal Year 2024 Detailed Accounting Submission and Fiscal Year 2026 Budget Formulation Compliance Report for National Drug Control Activities, and the Accompanying Required Assertions (OAS-25-03-016), January 2025	-	-	-	-
A Review of Pandemic Relief Funding and How It Was Used in Six U.S. Communities: Marion County, Georgia (OEI-06-22-00470), January 2025	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
A Review of Pandemic Relief Funding and How It Was Used in Six U.S. Communities: White Earth Nation Reservation in Minnesota (OEI-06-22-00480), March 2025	-	-	-	-
Indian Health Service (IHS)				
Staffing Shortages Limited IHS's Capacity To Effectively Administer Much-Needed Sanitation Projects Funded by the Infrastructure Investment and Jobs Act (OEI-06-24-00010), December 2024	-	-	-	-
National Institutes of Health (NIH)				
Most Institutions That Received NIH Funding Did Not Fully Understand When They Must Report Monetary Donations (OEI-03-22-00570), March 2025	-	-	-	-
Office of the Secretary (OS)				
HHS Continues To Make Progress Toward Compliance With the Geospatial Data Act (A-18-24-03500), October 2024	-	-	-	-
Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2024 (A-17-24-00001), November 2024	-	-	-	-
Review of the Department of Health and Human Services' Compliance With the Federal Information Security Modernization Act of 2014 for Fiscal Year 2024 (A-18-24-11200), November 2024	-	-	-	-
The Office for Civil Rights Should Enhance Its HIPAA Audit Program To Enforce HIPAA Requirements and Improve the Protection of Electronic Protected Health Information (A-18-21-08014), November 2024	-	-	-	-
Summary Report of Prior Office of Inspector General Cyber Threat Hunt Audits of Eight HHS Operating Division Networks (A-18-22-07002), December 2024	-	-	-	-
Response to OSC File #DI-20-000743: HHS Actions Related to Medical Countermeasures and Supplies to Respond to COVID-19 (OEI-09-20-00570), December 2024	-	-	-	-
OMB Memo for Government Charge Card Abuse Prevention Act of 2012 (OAS-25-04-007), January 2025	-	-	-	-
Substance Abuse and Mental Health Services Administration (SAMHSA)				
SAMHSA's FindTreatment.gov Contained Some Inaccurate Information on Substance Use and Mental Health Treatment Facilities (A-09-23-01003), March 2025	-	-	-	-
Total Reports: 78	**$189,032,273**	**$12,648,581,404**	**$27,047,198**	**16[2]**

*****Contract audit per NDAA 2008, section 845.

[2] This figure represents management decisions on reports issued during the reporting period only. OIG has not yet received management decisions for most reports listed above because those decisions are not due to OIG until 6 months following the issuance of a report. For additional information on reports for which a management decision was made during the reporting period, including reports that were issued prior to the reporting period, see Appendix B.

Appendix B: Report Details

Audit Reports With Questioned Costs

OIG identified **$189 million in questioned costs** during the reporting period. The table below summarizes audit reports with questioned costs and HHS program officials' decisions to take action on these and other outstanding audit recommendations.

Table 2: Audit Reports With Questioned Costs (October 1, 2024–March 31, 2025)

		Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
A.	Reports for which no management decision has been made by the commencement of the reporting period*	22	$691,436,000	$366,866,000
B.	Reports issued during the reporting period†	16	$189,032,000	$27,047,000
	Subtotal (A + B)	**38**	**$880,468,000**	**$393,913,000**
Less:				
C.	Reports for a which management decision was made during the reporting period			
	i. Disallowed costs	12	**$450,575,000****	$371,834,000
	ii. Costs not disallowed	13	$271,150,000	$2,485,000
	Subtotal (i + ii)	**25**	**$721,725,000**	**$374,319,000**
D.	Reports for which no management decision has been made by the end of the reporting period [(A + B) – Subtotal C]	**13**	**$158,743,000**	**$19,594,000**
E.	Reports for which no management decision was made within 6 months of issuance‡	**3**	**$26,155,000**	-

* The opening balance was adjusted upward by $366,851,000 because of re-evaluations of previously issued recommendations.

† Four issued reports containing recommendations for both questioned costs and funds put to better use are counted in both tables.

** Audit receivables (expected recoveries).

‡Because of administrative delays, some of which were beyond management control, resolution of three audits were not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period.

DEFINITIONS

As defined by the Inspector General Act, the term **"questioned cost"** means a cost that is questioned by OIG because of: (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, the cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.

Unsupported costs are a subset of questioned costs; these are costs that OIG found that, at the time of the audit, are not supported by adequate documentation.

Questioned costs that HHS program officials have, in a management decision, sustained or agreed should not be charged to the Government are known as **disallowed costs**.

Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use

OIG identified **$12.65 billion in funds put to better use** during the reporting period. The table below summarizes audit reports with recommendations that funds be put to better use and HHS program officials' decisions to take action on these audit and evaluation recommendations.

Table 3: Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use (October 1, 2024–March 31, 2025)

	Number of Reports	Dollar Value
A. Reports for which no management decision has been made by the commencement of the reporting period*	3	$15,128,799,000
B. Reports issued during the reporting period†	7	$12,648,581,000
Subtotal (A + B)	**10**	**$27,777,380,000**
Less:		
C. Reports for which a management decision was made during the reporting period		
i. Value of recommendations agreed to by management		
a. Based on proposed management action	1	$465,078,000
b. Based on proposed legislative action	-	-
ii. Value of recommendations not agreed to by management	3	$15,132,590,000
Subtotal (i + ii)	**4**	**$15,597,668,000**
D. Reports for which no management decision had been made by the end of the reporting period** [(A + B) – Subtotal C]	**6**	**$12,179,712,000**

* The opening balance was adjusted downward by $366,851,000 because of re-evaluations of previously issued recommendations.

†Four issued reports containing recommendations for both questioned costs and funds put to better use are counted in both tables.

** Because of administrative delays, some of which were beyond management control, resolution of one of the five audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendation before the end of the next semiannual reporting period.

DEFINITIONS

The phrase **"recommendations that funds be put to better use"** means that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, de-obligation of funds, and/or avoidance of unnecessary expenditures.

Appendix C: Investigative Actions

During the reporting period, OIG's investigative work led to **$3.51 billion in investigative receivables** and **349 criminal actions**. OIG also **took civil actions, such as assessing monetary penalties, against 395 individuals and entities**, and **excluded 1,503 individuals and entities from Federal health care programs**. The following table summarizes OIG's investigative activities and results during the reporting period.[3]

Table 4: Investigative Activity and Results (October 1, 2024–March 31, 2025)

Investigative Receivables		
Amount due to HHS		$2,701,664,689
Amount due to non-HHS entities		$804,677,717
	Total Investigative Receivables	**$3,506,342,406**
Investigative Results		
Criminal actions resulting from investigations		349
Civil actions		395
Judgments/settlements		319
Civil monetary penalties		76
	Total Criminal and Civil Actions	**744**
Investigations closed		946
Referrals		
Referrals to the Department of Justice		1,099
Indictments and criminal informations resulting from referrals made prior to and during the reporting period		219
Referrals to State and local authorities		110
Indictments and criminal informations resulting from referrals made prior to and during the reporting period		79
	Total Referrals	**1,209**
Exclusions		
Individuals		1,476
Entities		27
	Total Exclusions	**1,503**

TYPES OF ENFORCEMENT ACTIONS

Civil actions include civil settlements and civil judgments, including actions resulting from the use of OIG's Civil Monetary Penalties Law authority.

Criminal actions include actions, such as convictions, that occur once an individual or entity's guilt is determined and a sentence is imposed, as well as when a defendant enters a pretrial diversion program before or after indictment.

OIG **excludes** individuals and entities from federally funded health care programs pursuant to section 1128 of the Social Security Act (42 U.S.C. § 1320a-7). Those that are excluded can receive no payment from Federal health care programs for any items or services they furnish, order, or prescribe. OIG primarily receives exclusion referrals from its Office of Investigations, Medicaid Fraud Control Units, and State licensing boards. OIG also identifies its own cases through online news media and other sources.

Referrals are presentations of OIG subjects to Federal, State, or local prosecuting jurisdictions for prosecutorial consideration.

[3] OIG issued no investigative reports, which are reports that identify or bring renewed attention to systemic weaknesses or vulnerabilities within HHS programs and recommend administrative, procedural, policy, regulatory, or legislative change to correct or minimize the problem during the reporting period.

Table 5: Investigations of Senior Government Employees (October 1, 2024–March 31, 2025)

OIG conducted 11 investigations of 13 senior Government employees (as defined in the IG Act). Of these investigations, 1 allegation was substantiated (investigation was reported publicly), and 10 allegations were either unsubstantiated or no determination was made (investigations were not reported publicly).

Substantiated

OIG investigated a senior Government employee (GS-15) for allegedly retaliating against a former employee for reporting a security violation. The complainant alleged that the complainant's supervisors and responsible management officials (RMOs) retaliated against the complainant for reporting a security violation. OIG investigators found that the RMOs suspended and subsequently revoked complainant's security clearance in retaliation for making a protected disclosure (public report). The OIG investigative report was provided to the Secretary of HHS and included a recommendation that the Secretary take appropriate action.

Unsubstantiated/No Determination Made and Not Reported Publicly

Description of Investigation
OIG investigated a senior Government employee (GS-15) for allegedly generating an anonymous letter of threats made against the employee by a subordinate.
OIG investigated a senior Government employee (GS-15) for allegedly being a counterintelligence risk. The employee was removed from Government employment.
OIG investigated a senior Government employee (GS-15) for allegedly engaging in contract fraud and accepting kickbacks.
OIG investigated a senior Government employee (GS-15) for alleged sexual harassment and false statements. The matter was referred to the HHS Operating Division.
OIG investigated a Presidential Appointee employee and a Senior Executive Service (SES) employee for allegedly expressing concerns about the treatment of a patient at a medical facility and, in their official capacity, threatening an investigation if that patient was not transferred out of that medical facility.
OIG investigated a senior Government employee (GS-15) for allegedly retaliating against another employee by giving a poor performance review after that employee reported mismanagement and an abuse of authority. The OIG referred this matter to the Office of Special Counsel (OSC).
OIG investigated two senior Government employees (GS-15) and one SES employee for allegedly retaliating against another employee after that employee reported multiple incidences where management used the contractor's recommendations to coerce employees to violate Federal regulations established for certain programs and program operations. OIG referred this matter to OSC.
OIG investigated a senior Government employee (GS-15) for allegedly retaliating against an employee after the employee reported their manager for abuse of authority and harassment. OIG referred this matter to OSC.
OIG investigated a senior Government employee (GS-15) for allegedly retaliating against another employee and creating a hostile work environment after the employee previously reported to his supervisor that they were experiencing a hostile work environment. The employee reached a settlement with the employer and the investigation was closed.
OIG investigated a senior Government employee (GS-15) for allegedly sexually assaulting someone several years prior. OIG determined the alleged crime was not committed on Federal property or during work hours and therefore jurisdiction would lie with local authorities.

Appendix D: Peer Reviews

Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE). The CIGIE peer review program provides OIGs and their stakeholders with an assessment of the OIG's compliance with relevant quality standards and its quality control systems (e.g., policies and procedures).

Office of Audit Services

During the reporting period, OIG's Office of Audit Services (OAS) did not receive a peer review. The most recent peer review OAS received was conducted by the Department of Housing and Urban Development (HUD) OIG, the final report of which was issued in March 2024. In that review, OAS received a "pass" rating and HUD-OIG issued no recommendations. OAS has no outstanding peer review recommendations. OAS did not conduct a peer review during the reporting period. The most recent peer review OAS conducted was of the Department of Defense OIG, the final report of which was issued in September 2024.

Office of Evaluation and Inspections

During the reporting period, OIG's Office of Evaluation and Inspections (OEI) did not receive a peer review. The most recent peer review OEI received was conducted by the Department of Energy (DOE) OIG, the final report of which was issued in February 2023. In that review, DOE-OIG determined that OEI's policies and procedures and the four reports reviewed generally were consistent and complied with the CIGIE Blue Book standards. OEI has no outstanding peer review recommendations. OEI did not conduct a peer review during the reporting period. The most recent per review OEI conducted was of the Special Inspector General for Afghanistan Reconstruction OIG, the final report of which was issued in March 2023.

Office of Investigations

During the reporting period, OIG's Office of Investigations (OI) did not receive a peer review; however, the United States Postal Service (USPS) OIG issued its final report for the peer review it conducted of OI in September 2024. In that review, USPS-OIG determined that OI's system of internal safeguards and management procedures for the investigative function was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines. OI has no outstanding peer review recommendations. OI initiated a peer review of the U.S. Department of Agriculture OIG during the reporting period. This review was still ongoing as of March 31, 2025.

Appendix E: Reporting Requirements

The National Defense Authorization Act (NDAA) of Fiscal Year 2023, section 5273, amended the Inspector General Act of 1978 and the Inspector General Empowerment Act of 2016 to streamline semiannual reporting requirements for offices of inspectors general, which now appear in the note of 5 U.S.C. § 405. The following table presents the new NDAA requirements and other remaining requirements, along with the location of the information in this report.

Section	Requirement	Location
U.S.C. § 405 (note)		
5(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
5(a)(2)	Recommendations for which corrective action has not been completed	OIG Impact from Recommendations and OIG's Recommendations Tracker
5(a)(3)	Significant investigations closed during the reporting period	Throughout this report
5(a)(4)	Convictions during the reporting period	Appendix C: Investigative Actions
5(a)(5)	Information regarding reports issued during the reporting period	Appendix A: Audits and Evaluations
5(a)(6)	Information regarding any management decision made during the reporting period with respect to any report issued during a previous reporting period	At a Glance: OIG Accomplishments, OIG Impact from Recommendations, and OIG's Recommendations Tracker
5(a)(7)	Information required by the Federal Financial Management Improvement Act of 1996	None this reporting period
5(a)(8)	Results of peer reviews of HHS-OIG conducted by other OIGs	Appendix D: Peer Reviews
5(a)(9)	Outstanding recommendations from peer reviews of HHS-OIG conducted by other OIGs	Appendix D: Peer Reviews
5(a)(10)	Peer reviews of other OIGs conducted by HHS-OIG	Appendix D: Peer Reviews
5(a)(11)	Investigative statistical tables	Appendix C: Investigative Actions
5(a)(12)	Metrics description for investigative statistical tables	Appendix C: Investigative Actions
5(a)(13)	Investigations of senior Government employees	Appendix C: Investigative Actions
5(a)(14)	Description of whistleblower retaliation instances	Additional OIG Activities
5(a)(15)	Description of attempts to interfere with OIG independence	None this reporting period
5(a)(16)	Descriptions of investigations of senior Government employees	Appendix C: Investigative Actions
5(a)(16)	Descriptions of nonpublic reports	Appendix A: Audits and Evaluations
Other Requirements		
NDAA 2008, § 845	Significant contract audits	Appendix A: Audits and Evaluations
SSA § 1128D Health Insurance Portability and Accountability Act	Public proposals for new and modified safe harbors	Additional OIG Activities

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OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

Scan to Report at

TIPS.HHS.GOV

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TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.